

Building



a Better Mental Health Workforce

8 Core Elements

ABSTRACT: The field of behavioral health is facing a national crisis surrounding its workforce. Critical issues include problems in recruitment and retention and a serious lack of relevant preparation for work in mental health settings. This article identifies the challenges inherent in providing effective education and training to mental health staff who hold a bachelor's degree or less formal education. Key theories, concepts, and general principles of critical importance to all staff expected to work in a redesigned or transformed mental health system are described. Best and promising practices are contrasted with current practices, and specific recommendations including core concepts and competencies are listed, leading to the development of a training curricula targeted to meet these needs.

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Mental illness ranks first among illnesses that cause disability in the United States, Canada, and Western Europe (New Freedom Commission on Mental Health, 2003). Mental illness is a serious public health issue and one that costs approximately \$71 billion per year to treat in the United States alone (New Freedom Commission on Mental Health, 2003). The majority of mental health care is provided through publicly funded primary care clin-

ic, state psychiatric inpatient facilities, community mental health centers, emergency departments, state-funded residential and group facilities, and outpatient clinics by a variety of staff, roughly divided into professional licensed and nonlicensed subgroups (New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services [USDHHS], 1999).

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It is widely believed that a majority of the current mental health workforce has not been well prepared for practice in the trauma-informed, evidence-based, and recovery-oriented service settings that have been identified as cornerstones of the national vision for a transformed system of mental health care (Mazade, 2005; National Association of State Mental Health Program Directors [NASMHPD], 2005; New Freedom Commission on Mental Health, 2003). In fact, although policy makers are involved in

revising regulations, standards of practice, expected outcomes, and reallocating funding, almost no concerted, standardized action has been taken to revise current academic curricula or the content of pre-service education used to introduce these new values, concepts, or best practices to the current workforce (Canady, 2005). An informed and skilled workforce is critical to make this national vision a reality, and this work needs to be accomplished in a way that involves the cur-

ports (e.g., housing and employment opportunities), workforce turnover, and a lack of evidence-based practices were contributing to an ineffective system that was failing to meet the needs of its citizens (New Freedom Commission on Mental Health, 2003).

Both the Institute of Medicine's (IOM) (2001) report *Crossing the Quality Chasm: A New Health System for the 21st Century* and the New Freedom Commission on Mental Health's report (2003) identify the critical need to redesign academic and continuing education curricula. A well-prepared workforce is critical to any fundamental improvement in our health care delivery systems (IOM, 2001). Both reports concluded that system redesign needs to be targeted to both licensed and nonlicensed professional staff to bring the current workforce up to par (Canady, 2005; IOM, 2001; New Freedom Commission on Mental Health, 2003). Clearly, this is a daunting task that will significantly affect the "...role, self-image, and work of front-line... staff" (IOM, 2001, p. 20). Leaders, educators, instructors, human resource directors, and mentors will need current knowledge and skills to ensure this new knowledge and resultant new competencies will be transferred into practice at the service level.

Staff who do not have advanced degrees constitute a large and significant component of the mental health workforce (Manderscheid et al., 2004; Styron, Shaw, McDuffie, & Hoge, 2005). These workers are usually recognized by titles such as RN and have been prepared for practice in 2-year or 4-year degree programs but as generalists, not mental health specialists. The staff they supervise include mental health technicians and psychiatric aides. These staff comprised an estimated total of 227,083



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BACKGROUND

The New Freedom Commission on Mental Health published its report in 2003. The Commission (2003) declared the U.S. mental health delivery system was fragmented and in disarray, leading to costly and unnecessary disability, chronicity, recidivism, homelessness, and incarceration and affecting both adults and children. The Commission's report concluded that the current mental health system is not oriented to provide the hope necessary to facilitate recovery for the people it serves and that issues such as lack of access to quality care, poor communication among providers, lack of inclusion of consumers and families, inherent discriminatory practices, an overreliance on institutional care, a lack of community sup-

workers in 1998 (Manderscheid et al., 2004).

Although data are scarce, some literature indicates that nonlicensed direct care staff comprise between 40% and 60% of the current public mental health inpatient and outpatient employee base (Hoge & Morris, 2002). It is these staff members who spend the majority of time with service recipients in community mental health centers, hospitals, and residential programs. These staff generally receive some pre-service training and new employee orientation on employment, as well as additional staff development courses provided by employers to meet facility licensure or accreditation standards and external continuing education as a requirement for continued nursing licensure or certification. However, there is little evidence that these kinds of educational activities influence practice patterns in the long term or that knowledge presented in these activities leads to behavioral changes (Daniels & Walter, 2002).

THE VISION OF THE NEW FREEDOM COMMISSION ON MENTAL HEALTH

The New Freedom Commission on Mental Health report (2003) clearly identifies the vision of a transformed mental health system, stating that:

successfully transforming the mental health service delivery system rests on two principles:

- First, services and treatments must be consumer and family centered, geared to give consumers real and meaningful choices about treatment options and providers—not oriented to the requirements of bureaucracies.
- Second, care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery,

and on building resilience, not just managing symptoms. (p. 5)

As defined in the Commission's report (2003), recovery refers to the "process in which people are able to live, work, learn, and participate fully in their communities" (p. 5). For some, recovery is about living a personally meaningful life despite a disability, whereas for others, recovery means a complete remission or significant reduction in symptoms (New Freedom Commission on Mental Health, 2003). Most of the research has identified the constructs implicit in facilitating recovery to be the provision of hope, learning how to manage one's own illness, and getting on with life beyond the illness (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

Knowledge and evidence about the phenomenon of recovery from mental illness have been in the literature for years (Ralph, 2000). However, change in the mental health service system has been slow and continues to lag behind the evidence (IOM, 2001; Substance Abuse and Mental Health Services Administration [SAMHSA], 2005; USDHHS, 1999). Academic curricula designed to prepare clinicians to work in current mental health settings are decades behind current research, and knowledge and codes of ethics are not specifically relevant enough to drive practice forward or facilitate recovery in people being served in the mental health service system (New Freedom Commission on Mental Health, 2003). Although the consumer movement, beginning in the 1950s, has come a long way in informing mental health policy makers about recovery and identifying gaps in the current system of care, the mental health system has also been reluctant to ensure full consumer participation in their own care, let alone invite

them to the table as partners in determining mental health public policy (IOM, 2005).

The New Freedom Commission on Mental Health identified 6 goals and 19 recommendations that support the recovery vision and attempt to provide direction for system change. Of high priority are the goals to make mental health care consumer and family driven, eliminate disparities in service provision, adopt promising and evidence-based practices, and use technology to improve access to care and information transparency (New Freedom Commission on Mental Health, 2003). These goals reflect strong philosophical and value-laden statements that clearly separate the current system of care from the transformed system envisioned by the Commission.

THE IOM'S 10 RULES FOR REDESIGNING HEALTH CARE

The IOM's (2001) report presented 10 rules to guide a redesigned health care system. Some of these rules include a call for care based on continuous healing relationships; care based on individual needs and values; the patient as source of control; shared knowledge and transparency of information; evidence-based practice; safety as a priority; preventive, proactive (as opposed to reactive) care; and clinician cooperation (IOM, 2001). These rules are relevant to the mental health workforce and are in concert with the goals included in the latest IOM report (2005), which is specific to mental health and substance use conditions.

CORE ATTITUDES, KNOWLEDGE, SKILLS, AND COMPETENCIES REQUIRED FOR THE MENTAL HEALTH WORKFORCE

Improving the quality of care and service delivery in mental

health settings depends on the attitudes, knowledge, and skills of the mental health workforce whose job it is to deliver high-quality, compassionate care (Styron et al., 2005). These attitudes, knowledge, and skills come together to form behavioral competencies that can be observed and measured in performance evaluations and annual competency reviews. However, the public mental health field has not identified, standardized, or implemented a core set of portable constructs or competencies for direct care staff in any cohesive manner.

The IOM developed specific recommendations for workforce development in its 2003 report titled *Health Professions Education: A Bridge to Quality*. The IOM commissioned a multidisciplinary committee that proposed “a set of five core competencies that all clinicians should possess regardless of discipline” (IOM, 2003, p. 3). These included the provision of person-centered care, working in interdisciplinary teams, using evidence-based practices, applying quality improvement principles, and using informatics (IOM, 2003). These are viewed as important, global competencies and can be considered overriding themes to be included when framing specific competencies targeted to various disciplines.

Morris and Stuart (2002) described the need for training for consumers, family members, and direct service workers. They supported the need for a national training initiative, recommending core competencies. A review of the workforce literature found six fully developed, portable curricula for direct care mental health staff (Styron et al., 2005). However, these core curricula present obstacles to adoption in any standardized manner, across settings and states. For example,

three of them are proprietary and costly, one is for children only, and three mandate a psychosocial rehabilitation approach to care. Another curriculum—the family-to-family education program—is directed toward families and caregivers and is comprehensive, is available to all, and has been used in 18 states and in Canada (National Alliance on Mental Illness, n.d.). However, although none of these existing curricula contain the minimum competencies that are widely generalizable for mental health staff working in child, adolescent, adult, and forensic facilities, these works are of significant value and inform next steps. They lead the development of transdisciplinary competencies for all staff working in mental health settings and include eight dimensions that will be described in the following sections.

Knowing the Signs and Symptoms of Mental Illness and Diagnostic Practices

Many direct care workers lack sufficient knowledge about the signs and symptoms of serious mental illness (in adults) and emotional disturbance (in children) and therefore are not prepared to educate consumers or their families (Morris & Stuart, 2002). This is critical knowledge required of all workers to provide effective consumer-centered care (IOM, 2003). Although there is often an unspoken expectation that direct care staff have some knowledge of the illnesses experienced by the people they serve, this expectation has not been substantiated by research or reality.

Nurses prepared in 2-year, associate degree programs enter the workforce with little theory and minimal clinical experience designed to prepare them to provide evidence-based care in mental health settings. In the author's

experience, the majority of mental health technicians have never taken formal classes on the signs and symptoms of mental illness or the use of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (2000), or know much about the purpose, use, or side and adverse effects of medications used to treat mental disorders, let alone other treatment practices. Most of this knowledge is learned from coworkers or dated literature (Styron et al., 2005).

In addition to a lack of formal knowledge, staff can bring attitudes, personal experiences, and learned beliefs to bear on the behaviors they encounter (NASMHPD, 2005). As a result, service user behaviors are sometimes given meanings based on uninformed beliefs. Statements such as “We can't let him get away with that,” “I would not let my kid do that,” and “She needs to understand consequences” testify to these informal but pervasive beliefs and attitudes (NASMHPD, 2005).

Adopting Best Practices in the Use of Psychiatric Medications

The usefulness and best use of some psychotropic medications are under scrutiny. Recent findings indicate that the decades-old practice of intense marketing of atypical antipsychotic agents by pharmaceutical companies has been uninformed by outcomes (Lieberman et al., 2005). Worse, this marketing appears to have positively affected prescribing practices. Two recent studies (Jones et al., 2006; Lieberman et al., 2005) demonstrate surprising findings: first, that the newer atypical antipsychotic medications do not offer much more overall relief than do the older, typical antipsychotic

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agents; the newer medications offer, at best, a modest reduction in symptoms; and second, that the side effects of both the older and newer agents need to be clearly identified and monitored. According to Tandon (2006), health care providers and service users have to “pick the poison,” for example, extra-pyramidal symptoms, potential tardive dyskinesia, obesity, hyperlipidemia, or diabetes.

Mental health staff have adopted an overreliance on medications, a staple of treatment in psychiatric settings for many years. These new findings strengthen the call for individual treatment, adjunctive therapies (e.g., peer support), and psychiatric rehabilitation, and stress the importance of the therapeutic alliance between staff and services users. It is especially important for nurses to be cognizant of the risks and benefits of psychotropic medications for the people they educate and serve daily.

Understanding the Emerging and Significant Issue of Trauma and Coercion

Only recently has the experience of trauma and violence, historically linked with combat and disasters, been identified as a significant issue for a majority of individuals seeking mental health and substance abuse services in the United States (Cusack, Frueh, Hiers, Keane, & Mueser, 2003). Emerging evidence implicates traumatic events in major public health issues such as criminality, substance abuse, and academic and vocational dysfunction, and in physical and mental illnesses. The prevalence of trauma and posttraumatic stress disorder (PTSD) in the general population is much higher than was previously thought and is associated with high rates of medical and mental

health services use, making these some of the costliest underdiagnosed problems in American health care today (Felitti et al., 1998; Nemeroff, 2004).

Consumers, advocates, clinicians, and policy makers have identified a wide range of trauma-associated problems that need attention, including acute stress disorders, PTSD, dissociative identity disorder, and other symptoms such as self-harm behaviors (Jennings, 2004). Also prioritized was the retraumatization of trauma survivors through the widespread use of coercive interventions, such as forced medication and seclusion and re-

able people to live more satisfying, autonomous, and productive lives through focused and outcome-based interventions targeted toward individuals, families, groups, communities, and society in general (Harris, Maloney, & Rother, 2004). All mental health workers' jobs include acting as catalysts to discover issues and form therapeutic partnerships with service recipients to identify and practice solutions to complex human problems (Harris et al., 2004). To be effective, all mental health workers must understand the fundamentals of rapidly creating a therapeutic alliance that will lead to a rela-

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straint (American Association of Community Psychiatrists, 2003; Center for Mental Health Services & Human Resource Association of the Northeast, 1995).

A recovery-oriented system of care must, first and foremost, be informed by the prevalence of trauma among the people it serves; understand the neurological, biological, social, and emotional effects of trauma; and be cognizant of the lack of knowledge about trauma among staff and the potential for retraumatization within the mental health system (Huckshorn, 2004; NASMHPD, 2005).

Adopting Principles to Create Therapeutic Interpersonal Alliances with Service Recipients

The overall goal of mental health services work is to en-

tionship that creates hope and is based on interpersonal safety, trust, respect, and dignity; the ability to make choices and experience consequences; and the courage to take risks and make mistakes without fear of rejection or criticism.

The historically taught and nearly “lost” approach relevant to this is the Rogerian model that teaches the core competencies of empathy, unconditional positive regard, and belief in the potential for self-actualization, which is, in this case, another word for recovery (Ivey & Simek-Downing, 1980). It is disturbing that this basic humanistic approach seems to have been abandoned in current public mental health service settings.

Empowerment is another concept used to describe a relation-

ship that is reciprocal between helper and helpee (Harris et al., 2004). Empowerment is defined as people's "ability to manage their lives, recognize and meet their needs and to fulfill their potential as creative, responsible, and productive members of soci-

the use of seclusion and restraint, polypharmacy practices, and homogenized, "one size fits all" treatment activities (Mohr & Pumariega, 2004; NASMHPD, 2005). Most of these practices evolved due to well-intentioned efforts to improve people's lives, but these

come (Hyde et al., 2003, p. 16). Some of the well-documented practices that are now supported by strong research evidence and fidelity measures include illness management and recovery, assertive community treatment, medication algorithms, family psychoeducation, integrated services for adults with co-occurring disorders, cognitive-behavioral therapy, consumer self-help and peer support services, motivational interviewing, multisystemic therapy for children and families, and therapeutic foster care (Hyde et al., 2003). It will be important for mental health workers at all levels to be aware of and understand the role of these emerging practices, recognize what they look like, and know what outcomes they expect.



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ety" (Harris et al., 2004, p. 50). It can be inferred that a service system based on the construct of empowerment would be unique and would demand tremendous role and system changes from the workforce, service users, educators, and communities.

Becoming Familiar with Evidence-Based and Promising Practices

For years, the mental health field has lagged behind other health care arenas, including substance abuse, in basing practices on empirical research and evidence-based outcomes (Hyde, Falls, Morris, & Schoenwald, 2003). This lack of informed knowledge has resulted in dependence on hypothetical theories and traditions that are based on intuition and best-guess experimentation in creating services for adults and children with serious mental illness and emotional disturbance, respectively (Hyde et al., 2003). For example, mental health systems in the United States are still commonly involved in practices that have no evidence base, including the use of some point and level systems, day treatment services for adults,

and other practices continue to be widely used without critical analysis of their results or determination of their effectiveness (Hyde et al., 2003).

In 1999, the U.S. Surgeon General's report brought to public awareness the current need for attention to emerging research on mental health disorders. The report was quickly followed by an explosion in the mental health literature of what is now known as evidence-based and promising practices founded on rigorous study, analysis, and positive outcomes. There are still insufficient resources to immediately test all mental health practices, and rejecting those without evidence would paralyze the entire system of care. However, this topical issue has brought to the forefront the need for all mental health workers to understand this debate and what the evidence does and does not say about current practices, and to be involved in these discussions.

With the emergence of evidence-based practices, the mental health field has committed itself to a "new level of quality and accountability" that will drive its activities for years to

Partnering with People in Recovery in Formal Roles

People recovering from serious mental illnesses and who have been treated in public and private mental health settings have much to say about the care they have received (Bluebird, 2004). The most important phenomenon has been the propensity of mental health professionals, state mental health agencies, and regulatory bodies to discount or minimize these personal accounts of treatment experiences in lieu of believing "we know better" (Bluebird, 2004). The mental health consumer movement has struggled for years to build a knowledge base and credibility with policy makers. In the past decade, these voices have had effects at the federal, state, and local levels. Consumers are increasingly being invited to and given power at national and state policy, operations, and governance tables, but not on the local level. In local mental health settings, the willingness and availability of resources to fully include past

service recipients, their families, and advocates in daily agency operations has been very limited (NASMHPD, 2005).

To truly listen to and honor consumer experiences, and then to let those messages inform policy, creates both exciting opportunities and significant challenges. Doing so expects facility leadership to step outside of business as usual and move toward a fundamental culture change. It demands changes in values, vision, philosophy, assessment, treatment planning and provision, staff roles and expected competencies, and tolerance of risk, as well as an emphasis on prevention of, rather than reaction to, problems (NASMHPD, 2005). Doing so adjusts the power differential in mental health settings from one that is centered on staff to one that is shared and negotiated, with full respect of service recipients, no matter how ill they are. To achieve a transformed mental health system based on the goal of recovery, it is imperative to have a workforce completely indoctrinated in the value and power of full inclusion of service recipients in interdisciplinary teams, which are believed to be fundamental to effective health care (IOM, 2003).

Creating a Culturally Competent Workforce

A major challenge facing mental health service workers is in understanding the effects of cultural diversity on their daily work lives (Corey, Corey, & Callanan, 2003). Cultural diversity issues are encountered every day in mental health settings, and workers need education, guidance, and support to address these issues in a respectful and competent manner. Multicultural service provision seeks to clarify, explicate, and value the roles different cultures play in the lives of people seeking mental

health services and includes understanding and respect of gender, age, race, ethnicity, religion, sexual orientation, economic status, physical and/or emotional disability, and nationality. One significant issue is the need to change the predominant norms and values that primarily reflect the White, male population and that characterize the current approach to service recipients in many, if not most, mental health settings. This approach views people's thoughts, feelings, and behaviors against a stereotype that is unfair and unwarranted.

Multiculturalism is an attitude and philosophy to be taught, embraced, and enforced in mental health work settings (Corey et al., 2003). It requires a willingness to challenge usual thinking, values, and approaches; a fundamental shift in the willingness to see and value other people's needs, wishes, desires, and circumstances; an understanding of traditional insidious discrimination; and a commitment to ensure language competency, no matter the setting, cost, or language (Corey et al., 2003). Cultural competence must be demonstrated by the committed assurance to the availability (24 hours per day, 7 days per week) of competent interpreters in mental health settings because effective two-way communication is a necessity. It also includes the inculcation of person-first language. A culturally competent workforce that reflects the population served will positively affect the provision of consumer-centered care, the work of interdisciplinary teams, the use of evidence-based practices, and the ongoing assessment of service provision through quality improvement activities (IOM, 2003).

Formalizing the Role of Ethics in Practice

In the early 1970s, the National Organization for Human

Service Education and the Council for Standards in Human Service Education identified practice standards for educators and human service workers, including those with less than advanced degrees (*Codes of Ethics*, 2004; Harris et al., 2004). Despite this work, the majority of nonlicensed staff in the public mental health direct service workforce remains unaware of these standards or codes. These early attempts failed, probably because the need to fill these positions quickly took precedence over organizations' ability to demand formal competencies, which would have made hiring more difficult. Therefore, many of these workers have no degree, licensure, or certification standards to which they must adhere (Harris et al., 2004), and the majority of mental health workers with a bachelor's degree or less are unaware of the standards or ethics codes. Frequently, employers are either unaware of the available standards or unable to expect adherence.

Ethics codes exist for all human service workers in all disciplines (*Codes of Ethics*, 2004). There appear to be few, if any, ramifications for individuals who practice outside ethical boundaries, unless egregious violations occur and are discovered by independent parties (Huckshorn, 2005). This is an important issue; if the codes themselves do not ensure ethical practice, they have little meaning in the real world. Academic preparation, pre-service education, continuing education, and real-world practice need to be tied much more closely to professional codes of ethics if the codes are to be made meaningful and effective in ensuring the outcomes they purport to support. Otherwise, these codes of ethics will be ignored by workers who are unaware of their existence or become nothing

KEYPOINTS

1. The mental health direct service workforce requires standardized training that reflects recovery-oriented values and introduces best and promising practices that can start to implement measurable knowledge and practice changes.
2. This recovery-oriented workforce goal requires the development of standardized templates or curricula based on current research and available in the near future, rather than expecting academic institutions to produce them.
3. Mental health core competency curricula must be available at no cost, be amenable to revisions over time, and be able to be disseminated in a technologically sophisticated manner in multiple settings, including at the local level.

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more than verbiage that serves to falsely reassure professional associations. Standardizing the ethics codes for nonlicensed mental health workers holding positions such as mental health technician, psychiatric aide, case manager, and social worker assistant could do much to professionalize these roles. Educating public mental health authorities and human resource professionals and integrating these concepts into new employee orientations and job descriptions would be a constructive first step.

RECOMMENDATIONS FOR STANDARDIZED TRAINING

The IOM (2003) suggested steps toward developing the health care workforce, including a shared interdisciplinary effort in defining a common language regarding core competencies, such as providing consumer-centered care, working in interdisciplinary teams, using evidence-based practices, understanding the principles of quality improvement, and using informatics. The mental health field would be wise to integrate these suggestions into the development of a nationally accepted curriculum for direct service workers that could be imple-

mented across all mental health settings, both inpatient and outpatient. The author believes the core constructs described in this article address the provision of consumer-centered care and the use of evidence-based practice and greatly inform the skills necessary to work in interdisciplinary teams.

The use of consumers and family members as trainers has been proven to be particularly effective in changing the attitudes and beliefs of traditionally trained mental health staff (Styron et al., 2005). Hearing, firsthand, how the usual system of care has been experienced by service recipients and their families is often a powerful incentive to change behaviors that have been experienced as shaming, demeaning, disrespectful, confusing, and bereft of hope. It is strongly recommended that consumers and their families are included in a significant way in any training of direct care staff toward the goal of system transformation.

The development of a training curriculum for direct service mental health workers needs to proceed sooner, rather than later. However, most public sector mental health agencies have experienced significant budget

cuts; training is usually one of the first budget items to be reduced. Therefore, it will be important to be cognizant of the difficulty in disseminating this kind of training to direct service workers who are not mandated to receive it through certification, continuing education, accreditation, or licensure expectations. A strong case must be brought to local-level leadership that prioritizes the importance of this work and makes it easily accessible, user friendly, cost neutral, and adaptable to a variety of settings. This is no easy task. It is recommended that potential curriculum developers be well versed in a variety of technological options, including Web-based training, videoconferencing, self-study, and other methods that would greatly reduce the amount of work time necessary to train every mental health direct care staff member individually in face-to-face training.

Finally, a competency-based approach must be adopted because this is the only way to measure behavior change and improved outcomes. Competency-based approaches are traditionally used in teaching-learning-demonstration methods of training in which physicians and nurses are well versed. Thus, it will be important to study and adopt these approaches in developing curricula because the use of exclusively didactic teaching methods may not be effective in changing practices (IOM, 2003).

SUMMARY

It is believed that the public mental health direct service workforce requires standardized training in new values, emerging best and promising practices, and current standards of practice. This can be accomplished in a cost-effective and technological-

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ly sophisticated manner. This initiative awaits the development of a core curriculum that is based on current and substantive literature and that understands the settings in which the training must be provided and the workforce for which it is targeted. The remaining challenge is to develop this core curriculum and effectively use dissemination vehicles that are cost effective and not unduly burdensome on current systems of care.

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